Calvert Hospice

Life, healing, hope.

October 26, 2006

Linda Cole, Chief
Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Proposed Draft Revisions to COMAR 10.24.08 State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services

Dear Ms. Cole:

Calvert Hospice writes to comment on the proposed draft revisions to COMAR 10.24.08 State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services, specifically with regard to the hospice provisions. Calvert Hospice fully supports the comments of the Hospice Network of Maryland on the draft proposal, but wishes to add the following observations.

Proposed COMAR 10.24.08.12.A.1. contains the statement:

> Availability of multiple providers in order to enhance consumer choice has become increasingly important for policymakers and consumers as well. Although recent research has highlighted the absence of an effect from market structure on hospice use, it is important that adequate choice is maintained where the market will support it. (footnote deleted)

The Certificate of Need Task Force, convened by Maryland Health Care Commission (MHCC) Chairman Salamon in 2005, is the most recent public forum to have considered availability and accessibility of hospice services. The deliberations of that body contained in the Task Force's comprehensive report[1] reflect no such concern or conclusion on the part of the multitude of stakeholders represented both on the Task Force itself and among the many commenters on the Task Force's deliberations. Indeed, during the Task Force deliberations, any contention that unconstrained competition would be beneficial to the terminally ill of the State of Maryland was soundly refuted. Economic philosophies grounded in the benefits of competition are not supported by the facts with regard to hospice services. What was demonstrated before the Task Force is that unbridled competition in hospice services strains the survival of grass-roots, community-based, non-profit hospices and, most significantly, compromises the quality of patient care. Incorporating the conclusion in regulation that competition in hospice is "increasingly important for policymakers and consumers" goes directly against discussions in which the Task Force rejected a similar statement propounded by the staff.[2] It should be eliminated from the draft.

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[1] Report of the Certificate of Need Task Force, November 22, 2005. The Task Force recommended no change in Certificate of Need regulation for hospice.

[2] Report of the Certificate of Need Task Force, November 22, 2005, p. 117.

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There also is no support for the statement in the proposed regulations that "it is more difficult for a small number of rural hospice providers to absorb additional clients. . ." Hospices located in rural areas in this State have generally grown to accommodate any increased need in their jurisdictions. As one example, Calvert Hospice has grown to serve 20 per cent more patients between 2001and 2005. Because hospices are not constrained in their flexibility by having to plan years in advance for major construction projects of beds and facilities as are hospitals and other health care providers, hospices can respond promptly to increases in demand for services by expanding staff to meet that demand. In sum, this conclusory statement in the draft proposal should be eliminated.

Calvert Hospice also opposes the provision that would authorize "specialty hospices" in continuing care retirement communities (CCRCs). In the first instance, it appears that the MHCC is without statutory authority to create this special exception to the CON requirements for hospice and the need projections of the State Health Plan. The draft also offers no policy justification for the inclusion of this special category of hospice in regulation and no analysis of the potential effect of CCRC-based hospices on local, community-based providers. This proposal originated in 2005 with the request of the Erickson Communities to establish "specialty hospices" in its own facilities. Beyond that background, the proposal fails to acknowledge, let alone discuss, the demonstrable and complete absence of need for CCRC-based hospices. No analysis of current hospice utilization in CCRCs has been done. In fact, the vast majority of CCRCs in Maryland are already well-served by one or more community-based hospices. Moreover, effectively removing the CCRC population from community-based hospices would eliminate an important segment of the potential hospice market that is now being served by local agencies. The proposal should be rejected as merely a back-door effort to avoid the requirements of the CON provisions for hospice that is not supported by the law or the facts.

Finally, Calvert Hospice joins with the comments of the Hospice Network regarding the proposed methodology for calculating future hospice need. Calvert Hospice agrees with the staff that "[f]uture trends in hospice utilization are also difficult to predict." The dramatic changes in hospice utilization over the last decade certainly make future predictions challenging. Unfortunately, as is well-documented in the Hospice Network's comments, the proposed methodology is seriously flawed and should be revised in accordance with the recommendations of the Hospice Network.

Calvert Hospice appreciates the opportunity to have commented on the proposed amendments to the State Health Plan for hospice.

Sincerely,

Lynn Bonde

Lynn Bonde
Executive Director

cc: HNM